

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18									
5709									
CERTIFICATE OF DEATH									
Reg. Dist. No. 05698									
1. PLACE OF DEATH a. COUNTY Kent MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Kent				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rock Hall			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rock Hall			d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION					d. STREET ADDRESS				
3. NAME OF DECEASED (Type or print) First Middle Last Barbara A. Abbate					4. DATE OF DEATH Month Day Year May 4 19 61				
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1887 Mar. 22-1901		9. AGE (In years lost birthday) 74 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Anton Schaefer					14. MOTHER'S MAIDEN NAME Unknown				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		INFORMANT		Address		
					Scott Vansant--Rock Hall, Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 334X Pulmonary Edema DUE TO (b) Hemiplegia - Left side DUE TO (c) Arterio Sclerosis - Hypertension CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from Oct 1 1958, to May 4 1961, that I last saw the deceased alive on May 4 1961, and that death occurred at 89 M, from the causes and on the date stated above. ACTUAL SIGNATURE Norbert C. Nitch M.D. ADDRESS "Raws-Hall" Md DATE SIGNED May 6/61 PHYSICIAN'S NAME (Type) Norbert C. Nitch Rock Hall, Maryland									
22a. BURIAL, CREMATION, REMOVAL Burial		22b. DATE THEREOF May 8		22c. NAME OF CEMETERY OR CREMATORY Most Holy Redeemer			22d. LOCATION (City, town, or county) (State) Baltimore, Maryland		
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Edgar H. Lane Church Hill, Md.				24a. REC'D BY REGISTRAR DATE MAY 11 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas			

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 MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
 CERTIFICATE OF DEATH

05699

1. PLACE OF DEATH a. COUNTY KENT MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHESTERTOWN		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION KENT AND QUEEN ANNE		d. STREET ADDRESS 506 Cannon St	
3. NAME OF DECEASED (Type or print) CHARLES FAULKNER BEDWELL		4. DATE OF DEATH MAY 13 1961	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 8, 1961
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10b. KIND OF BUSINESS OR INDUSTRY —	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? UNITED STATES	
13. FATHER'S NAME ELWOOD BEDWELL		14. MOTHER'S MAIDEN NAME PAULINE SCOTT	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service) —		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT MOTHER		Address 506 CANNON ST. CHESTERTOWN, MD	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 776X DUE TO Prematurity Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO _____ (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 5/8/61 to 5/13/61 , that (I) (we) last saw the deceased alive on 5/13/61 , and that death occurred at 5P M. from the causes and on the date stated above.			
22a. SIGNATURE Wm. M. Gatewood		22b. DATE SIGNED 5-14-61	
22c. PHYSICIAN'S NAME (Type) WM. M. GATEWOOD		22d. ADDRESS CHESTERTOWN, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 5-14-61	23c. NAME OF CEMETERY OR CREMATORY CHESTER CEMTY	23d. LOCATION (City, town, or county) (State) CHESTERTOWN MD
24. FUNERAL DIRECTOR'S SIGNATURE Victor N. Kennedy		25a. REC'D BY REGISTRAR STILL BND MD	
25b. REGISTRAR'S SIGNATURE Walter L. Thomas		DATE MAY 16 1961	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

5711

05700

1. PLACE OF DEATH a. COUNTY Kent MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown			c. LENGTH OF STAY IN 1b 22 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kent & Queen Anne's Hospital				d. STREET ADDRESS RFD#1		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Samuel Middle Tilden Last Cooper				4. DATE OF DEATH Month 5 Day 4 Year 1961			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/20/76		9. AGE (In years last birthday) 84 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Agriculture		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Samuel Cooper			14. MOTHER'S MAIDEN NAME Adatha Rasin				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 215-38-1237		17. INFORMANT Bertha Cooper Layhen, RFD#1, Chestertown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary infarct DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH 22 days 15 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 4/12 1961 to 5/4 1961 , that (I) (we) last saw the deceased alive on 5/3 1961 , and that death occurred 8:10am , from the causes and on the date stated above.							
22a. SIGNATURE A. C. Dick, M.D.				22b. ADDRESS Chestertown, Maryland		22c. DATE SIGNED 5/4/61	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 7/61		23c. NAME OF CEMETERY OR CREMATORY Chester Cemetery		23d. LOCATION (City, town, or county) (State) Chestertown, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Marvin V. Williams		ADDRESS Chestertown, Md.		25a. REC'D BY REGISTRAR DATE MAY 8 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Hume	

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CHURCHILL

STATE OF NEW YORK

OFFICE OF THE ATTORNEY GENERAL

IN SENATE

January 1, 1900

REPORT

OF THE

COMMISSIONERS

OF THE LAND OFFICE

FOR THE YEAR

1899

ALBANY:

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PRINTERS

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

65701

1. PLACE OF DEATH a. COUNTY Kent MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown		c. LENGTH OF STAY IN 1b adult life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Elm St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Henrietta Agnes Cosden		4. DATE OF DEATH May 4, 1961	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 20, 1876
9. AGE (In years last birthday) 84 yrs.		10. IF UNDER 1 YEAR Months Days 11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Talbot Co. Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Martin Donlin		14. MOTHER'S MAIDEN NAME Mary Farley	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 214-03-6569	
17. INFORMANT Catherine Short		Address Elm. St. Chestertown, Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) Coronary artery disease DUE TO (c) Arteriosclerosis			INTERVAL BETWEEN ONSET AND DEATH 1 week 2 years 10 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arthritis			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1-27 to 5-4 , that (I) (we) last saw the deceased alive on 5-3 1961 , and that death occurred on 5-4 1961 at 3:30a M., from the causes and on the date stated above.			
22a. SIGNATURE A. C. Dick		22b. DATE SIGNED 5/4/61	
22c. PHYSICIAN'S NAME (Type) A. C. Dick		22d. ADDRESS Chestertown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF May 6, 1961	23c. NAME OF CEMETERY OR CREMATORY Chester Cemetery	23d. LOCATION (City, town, or county) (State) Chestertown, Md.
24. FUNERAL DIRECTOR'S SIGNATURE J. Willis Wells		25a. REC'D BY REGISTRAR MAY 8 '61	
ADDRESS Chestertown, Md.		25b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

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[Faint, mostly illegible text covering the majority of the page, appearing to be a list or series of entries.]

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TO HOSPITAL: The low requires that the death certificate be executed within 24 hours after death. Page 4
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VR A15 (4)
15M 9/59

5713

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

05702

1. PLACE OF DEATH a. COUNTY Kent MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown		c. LENGTH OF STAY IN 1b 20 hrs, 15 min.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kent & Queen Anne's Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First John Middle Thomas Last Crouch		4. DATE OF DEATH Month 5 Day 5 Year 19 61	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/28/92
9. AGE (In years lost birthday) 68 yrs.		10. IF UNDER 1 YEAR Months 68	11. IF UNDER 24 HRS. Days 68 Hours 68 Min. 68
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Yacht captain		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Richard Crouch		14. MOTHER'S MAIDEN NAME Mary Stauffer	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 218 12 1872	
17. INFORMANT Gladys G. Crouch, Rock Hall, Md. (wife)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) Arteriosclerotic Heart Disease DUE TO (c) Arteriosclerotic Heart Disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic Heart Disease INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Aug 1958 to 5/5/61 19 61 , that (I) (we) lost saw the deceased alive on 5/5/61 19 61 , and that death occurred at 7:00 P. M. from the causes and on the date stated above.			
22a. SIGNATURE William M. Gatewood		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) William M. Gatewood, M.D.		22d. ADDRESS Box 106, Rock Hall, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 5/8/61	
23c. NAME OF CEMETERY OR CREMATORY Wesley Chapel		23d. LOCATION (City, town, or county) (State) Rock Hall Md	
24. FUNERAL DIRECTOR'S SIGNATURE Edgar L Lane		24b. ADDRESS Choroch Hill	
25a. REC'D BY REGISTRAR DATE MAY 11 '61		25b. REGISTRAR'S SIGNATURE Arthur L. Kline	

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FOR STATE
HEALTH DEPT.

TO DEPT. OF HEALTH: This certificate should be executed within 24 hours after death. If necessary, please execute the certificate, writing the word "pending" in pencil in item 18, Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

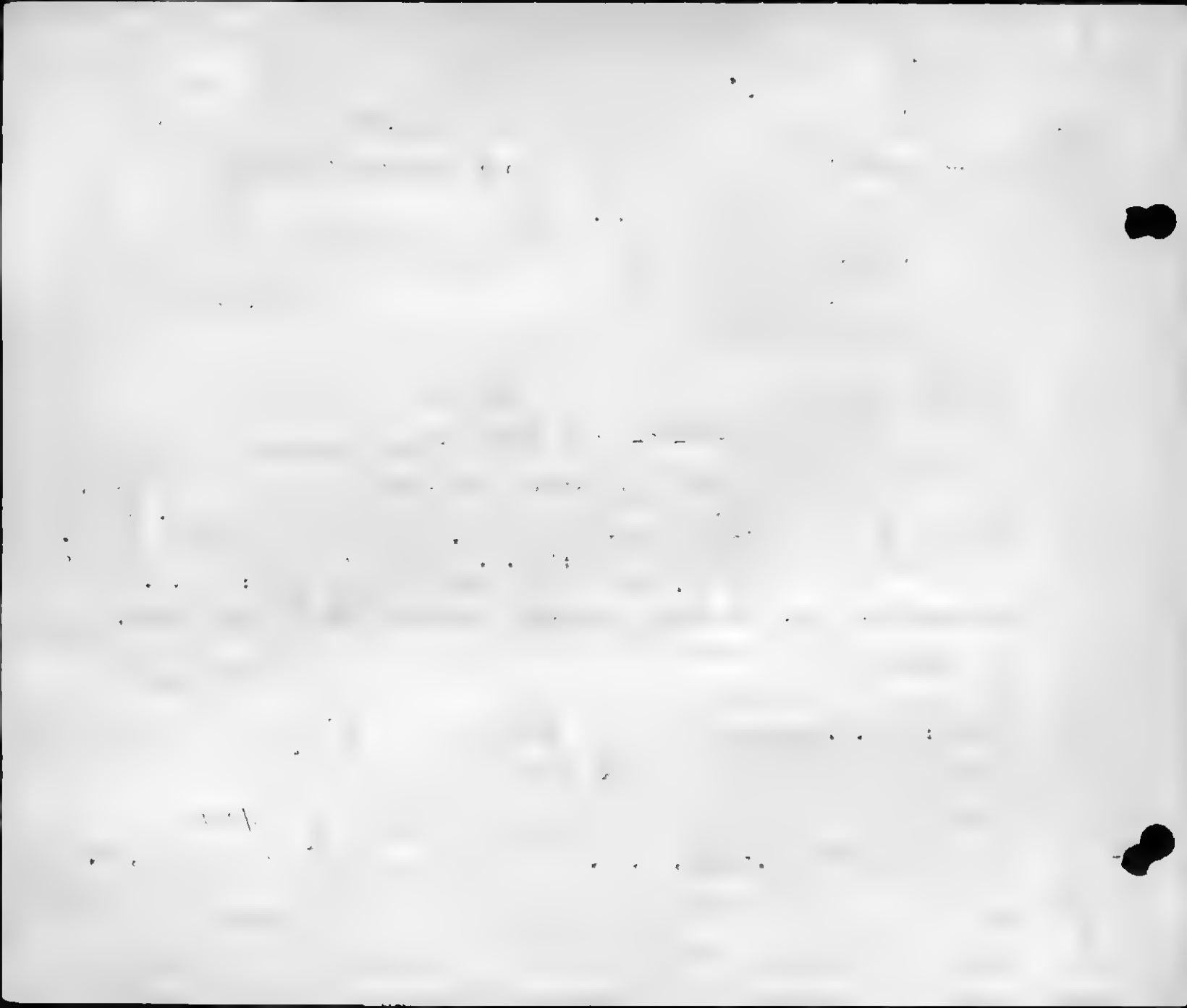
MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Kent		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Galena (Rural)		c. LENGTH OF STAY IN town Kent & Queen Anne's Hospital D.O.A.		d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Kent & Queen Anne's Hospital D.O.A.		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
2. NAME OF DECEASED (Type or print) James Allen Green		3. DATE OF DEATH Month May Day 19 Year 61		4. AGE (In years) IF UNDER 1 YEAR, IF UNDER 24 HRS. Last birthday 60 yrs. estimate 60 Months 0 Days 0 Hours 0 Min. 0		5. BIRTHPLACE (State or foreign country) South Carolina (?)		6. CITIZEN OF WHAT COUNTRY? USA	
7. SEX male		8. COLOR OR RACE colored		9. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		10. DATE OF BIRTH		11. BIRTHPLACE (State or foreign country) South Carolina (?)	
12a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer		12b. KIND OF BUSINESS OR INDUSTRY farm		13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) 578-07-0062	
16. SOCIAL SECURITY NO. 578-07-0062		17. INFORMANT Employer		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: Probable drowning or asphyxia IMMEDIATE CAUSE (a) Deceased was known to suffer from epilepsy. Had 2 seizures previous night. Last seen 12 Noon at lunch. Found about 3:15 P.M. lying face down in a puddle of water. Dead on arrival at hospital 4:55 P.M. Upper respiratory tract including pharynx contained mud & muddy water. DUE TO unknown DUE TO unknown DUE TO unknown PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. respiratory tract including pharynx contained mud & muddy water.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
21. TIME OF INJURY Month, Day, Year Between 1 & 3:15 P.M. 5/19/61		22. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not While at work <input type="checkbox"/>		23. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Farm		24. (City or town) Galena		25. (County) Kent	
26. (State) Maryland		27. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		28. CHIEF MEDICAL EXAMINER Robert W. Farr, M.D.		29. ASSISTANT MEDICAL EXAMINER 5/20/61		30. DATE SIGNED Chestertown, Md.	
31. ACTUAL SIGNATURE Robert W. Farr, M.D.		32. NAME (Type) Robert W. Farr, M.D.		33. ADDRESS (Street, city, town, or county) Chestertown, Md.		34. 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		35. 22b. DATE THEREOF May 23, 1961	
36. 22c. NAME OF CEMETERY OR CREMATORY Christ Hill Cem.		37. 22d. LOCATION (City, town, or country) Galena Kent Co. Md.		38. 23. FUNERAL DIRECTOR Edward Bellows, Mellington, Md.		39. 24b. REC'D BY REGISTRAR MAY 24 '61		40. 24c. REGISTRAR'S SIGNATURE C. S. Kline	

MEDICAL CERTIFICATION



TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

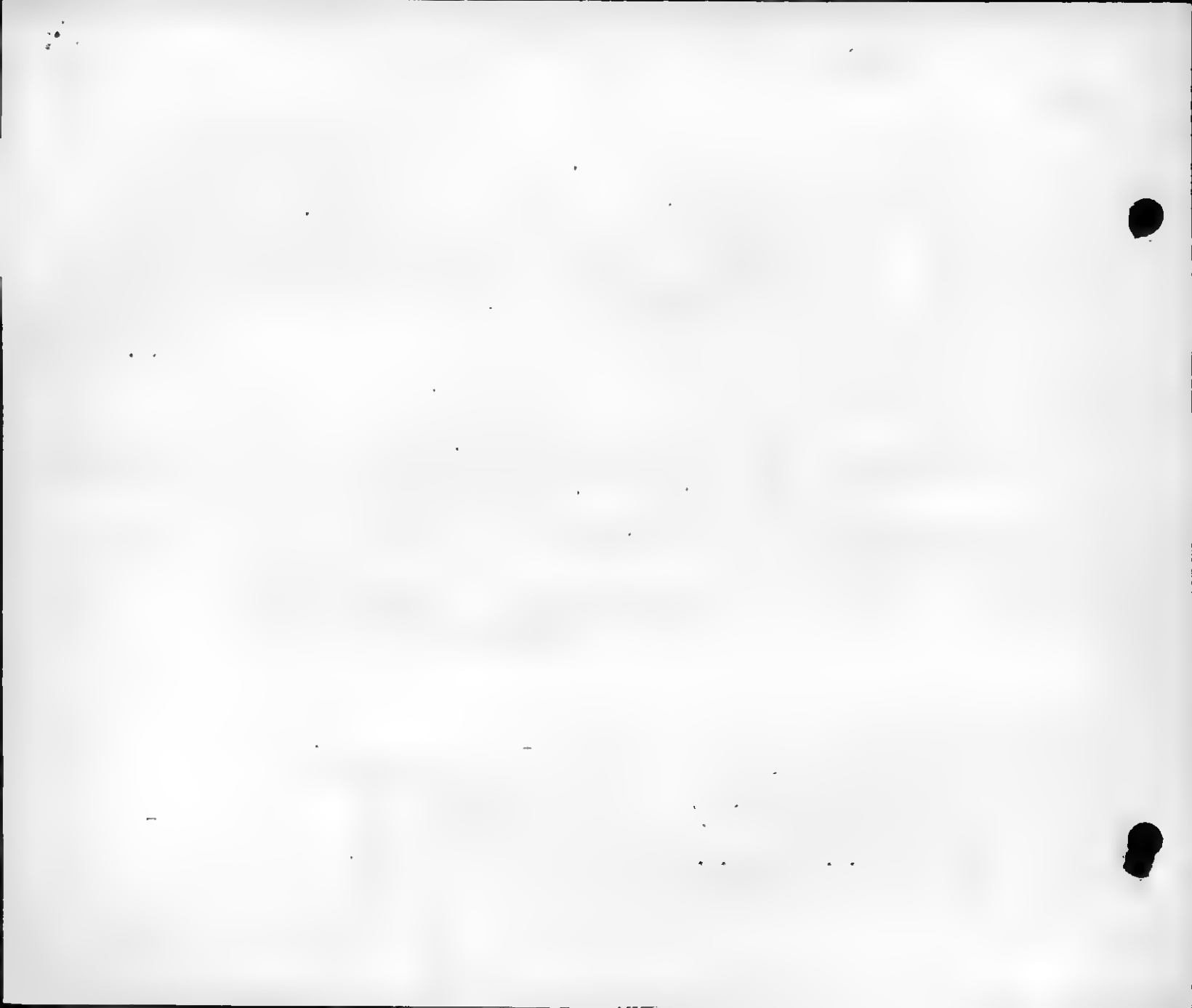
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

5715

05704

1. PLACE OF DEATH a. COUNTY Kent MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown				c. LENGTH OF STAY IN 1b 20 1/2 hrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kent & Queen Anne's Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Ethel Middle Mae Last Hopkins				4. DATE OF DEATH Month May Day 8 Year 19 61			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/6/85	9. AGE (In years last birthday) 76	IF UNDER 1 YEAR Months 76	IF UNDER 24 HRS Days 76 Hours 76 Min. 76	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Maryland		11. BIRTHPLACE (State or foreign country) U.S.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Franklin Pickett				14. MOTHER'S MAIDEN NAME Louise (unknown)			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. none		17. INFORMANT Robert C. Hopkins		Address Chestertown, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 4 days Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month May Day 19 Year 19 Hour a. m. p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 5-4 61 , to 5-8 61 , that (I) (we) last saw the deceased alive on 5-8 61 , and that death occurred at 9:35 a. m. on the causes and on the date stated above.							
22a. SIGNATURE <i>[Signature]</i>				22b. DATE SIGNED 5-8-61			
22c. PHYSICIAN'S NAME (Type) A.E. Dick, M.D.				22d. ADDRESS Chestertown, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 10, 1961		23c. NAME OF CEMETERY OR CREMATORY Chester Cem.		23d. LOCATION (City, town, or county) (State) Chestertown, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE <i>[Signature]</i>				25a. REC'D BY REGISTRAR DATE MAY 10 '61		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

MEDICAL CERTIFICATION



5716

CERTIFICATE OF DEATH

Reg. Dist. No.

05705

1 PLACE OF DEATH a. COUNTY <u>KENT</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>KENT</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ROCK HALL RURAL</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ROCK HALL RURAL</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>EDWARD W M LEARY</u>		4. DATE OF DEATH Month <u>MAY</u> Day <u>12</u> Year <u>1961</u>	
5 SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>FEB 14 1881</u>
9 AGE (In years last birthday) <u>80</u> yrs		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>MD</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CIT ZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>JAMES LEARY</u>		14 MOTHER'S MAIDEN NAME <u>MARY BURGESS</u>	
15 WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service)		16 SOCIAL SECURITY NO <u>214-42857</u> INFORMANT <u>W M MILLER</u> Address <u>ROCK HALL</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u> 120.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary Thrombosis</u> DUE TO (c) <u>Atherosclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>Unknown</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 10</u> , 19 <u>61</u> , to <u>May 12</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>May 12</u> , 19 <u>61</u> , and that death occurred at <u>130 P M</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Norbert C. Nitch</u> M D		ADDRESS (Street, city or town, state) <u>Rock Hall Md</u> DATE SIGNED <u>5-13-61</u>	
PHYSICIAN'S NAME (Type) <u>Norbert C. Nitch</u>			
22a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>5/14/61</u>	22c. NAME OF CEMETERY OR CREMATORY <u> Wesley Chapel</u>	22d. LOCATION (City, town, or county) (State) <u>Rock Hall Md.</u>
23 FUNERAL DIRECTOR'S SIGNATURE <u>Edgar L. Lane</u> ADDRESS <u>Church Hill</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 16 1961</u> 24b. REGISTRAR'S SIGNATURE <u>C. H. H. H.</u>	

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL: The low requires that the death certificate be executed within 24 hours after death. Page 4
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the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58

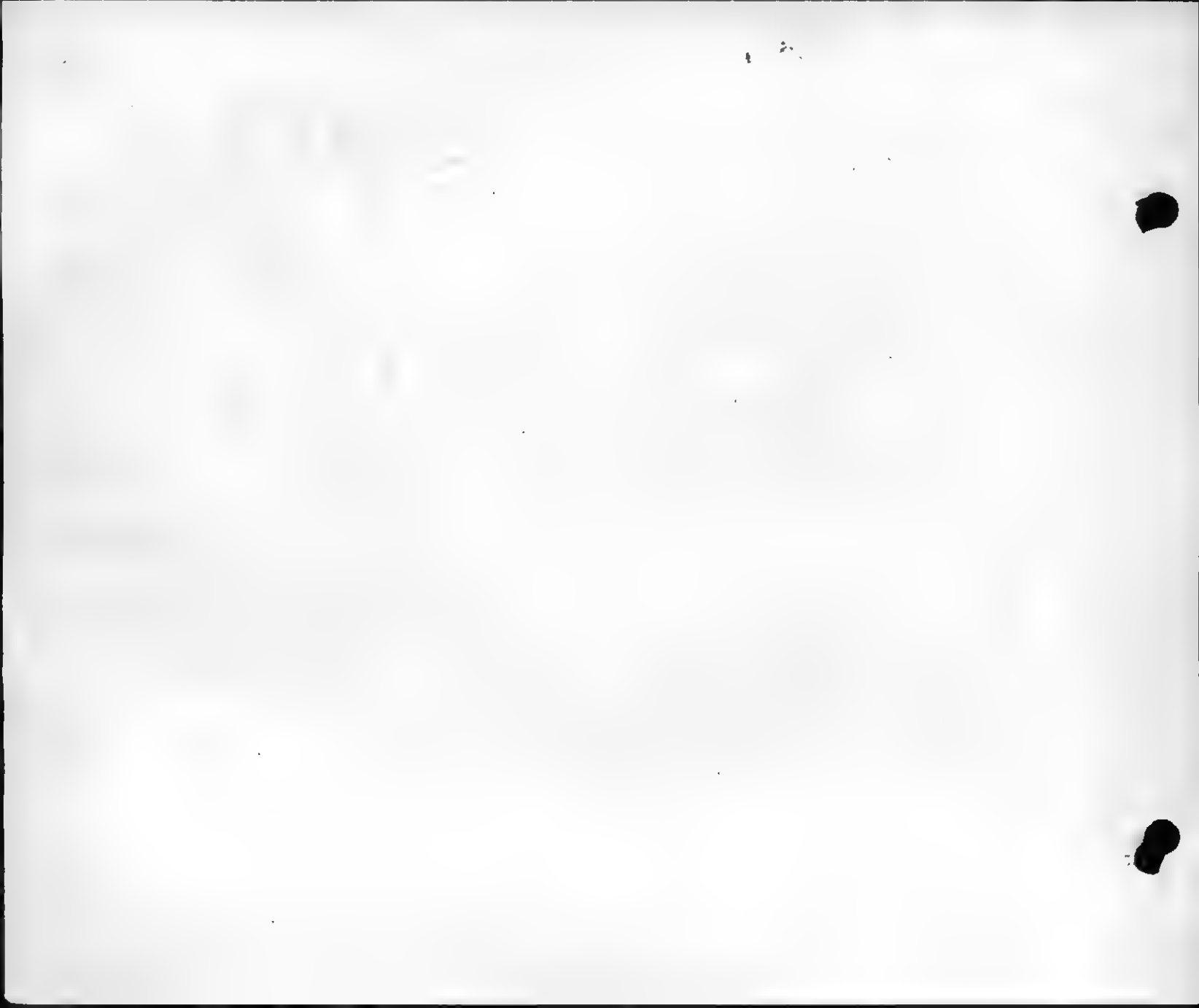
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5717

CERTIFICATE OF DEATH

Reg. Dist. No. 05706

1. PLACE OF DEATH a. COUNTY <i>Kent</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Kent</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rock Hall</i>		c. LENGTH OF STAY IN lb <i>life</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Chesapeake ave.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Lula</i> Middle <i>A.</i> Last <i>deary</i>		4. DATE OF DEATH Month <i>May</i> Day <i>6</i> Year <i>1961</i>	
5. SEX <i>F.</i>	6. COLOR OR RACE <i>W.</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>June 13 1879</i>
9. AGE (In years last birthday) <i>81</i> yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>home making</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>home</i>	
11. BIRTHPLACE (State or foreign country) <i>Kent Co. Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>Joseph Shanny</i>		14. MOTHER'S MAIDEN NAME <i>May Francis Stevens</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <i>No.</i>		16. SOCIAL SECURITY NO. <i>213-12-3245</i>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral hemorrhage</i> DUE TO Conditions if any, which gave rise to immediate cause (a), stating the underlying cause lost. <i>IX</i> DUE TO (b) _____ (c) _____ INTERVAL BETWEEN ONSET AND DEATH <i>about 2 hours</i>		18. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>5/6</i> 19 <i>61</i> , to <i>5/6</i> 19 <i>61</i> , that I last saw the deceased alive on <i>5/6</i> 19 <i>61</i> , and that death occurred at <i>4:30 PM</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <i>E. K. Lee</i> M.D. <i>Rock Hall, Md.</i> PHYSICIAN'S NAME (Type) _____			
22a. BURIAL CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<i>Burial</i>	<i>May 9/61</i>	<i>Wesley Chapel Am.</i>	<i>Rock Hall, Maryland</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Maurin V. Williams, Chelutuin, Md.</i>		24a. REC'D BY REGISTRAR <i>May 10 '61</i>	
		24b. REGISTRAR'S SIGNATURE <i>Clifford S. Howard</i>	



5718

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

05707

1 PLACE OF DEATH a. COUNTY Kent b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown		2. USUAL RESIDENCE (Where deceased lived f institution Residence before admission) a. STATE Maryland b. COUNTY Kent c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kent & Queen Anne Hospital		e. STREET ADDRESS 530 High St.	
3 NAME OF DECEASED (Type or print) First Middle Last James Edward Patrick		4. DATE OF DEATH Month Day Year May 15, 1961	
5 SEX male	6. COLOR OR RACE white	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 7, 1905
9. AGE (In years last birthday) 56		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		10b. KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (State or foreign country) Kent Co. Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME McKendree Patrick		14 MOTHER'S MAIDEN NAME Mary Knotts	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no		16. SOCIAL SECURITY NO. 219-05-6938	
17. INFORMANT Lillian Patrick		Address Chestertown, Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Infarct 420.1 DUE TO Extensive Coronary Sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 2 yrs (c)		INTERVAL BETWEEN ONSET AND DEATH 2 weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Infarction rt. Lung, Old Thrombosis Celiac & Sup. Mesenteric Arteries			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from April 30, 1961 to May 15, 1961 , that (I) (we) last saw the deceased alive on May 15, 1961 , and that death occurred at 6 A. M, from the causes and on the date stated above.			
22a. SIGNATURE R. W. Farr		22b. DATE SIGNED 5/15/61	
22c. PHYSICIAN'S NAME (Type) Robert W. Farr		22d. ADDRESS Chestertown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 17, 1961	
23c. NAME OF CEMETERY OR CREMATORY Chester Cem.		23d. LOCATION (City, town, or county) (State) Chestertown, Md.	
24 FUNERAL DIRECTOR'S SIGNATURE J. Willis Wells		25a. REC'D BY REGISTRAR MAY 18 '61	
ADDRESS Chestertown, Md.		25b. REGISTRAR'S SIGNATURE Arthur S. Harris	

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CERTIFICATE OF DEATH

Reg. Dist. No.

05709

1. PLACE OF DEATH a. COUNTY Kent MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional residence before admission) a. STATE Maryland b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Worton RFD		c. LENGTH OF STAY IN life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION at Home Coleman's corner		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Sylvester S. Tinch		4. DATE OF DEATH May 6, 1961 Month Day Year	
5. SEX male	6. COLOR OR RACE colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 3, 1961
9. AGE (In years lost birthday) yrs. 4		10. IF UNDER 1 YEAR Months Days Hours Min. 2	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, or if retired) none		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Kent CO. Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Sylvester Tinch		14. MOTHER'S MAIDEN NAME Gertrude Wilmore	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no	
17. INFORMANT Gertrude Wilmore Tinch Mother		Address Worton Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> 493X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO			INTERVAL BETWEEN ONSET AND DEATH 24 hr.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from birth, 1961, to May 6, 1961, that I last saw the deceased alive on May 4, 1961, and that death occurred at 12:30 AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Worton RFD Md. 5/6/61			
ACTUAL SIGNATURE Florence D. Joyce		M.D.	
PHYSICIAN'S NAME (Type) Florence D. Joyce			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 5/7/61	22c. NAME OF CEMETERY OR CREMATORY Coleman's Cem.	22d. LOCATION (City, town, or county) (State) RFD Worton, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Bennett W. W. W.		ADDRESS Chestertown, Md.	
24a. REC'D BY REGISTRAR DATE MAY 9 '61		24b. REGISTRAR'S SIGNATURE Charles S. Kline	

TO HOPEFUL OF ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

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TO BE FILLED BY ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
5721											
CERTIFICATE OF DEATH											
65710											
1. PLACE OF DEATH a. COUNTY Kent b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Georgetown c. LENGTH OF STAY IN 1b Home d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Home					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE Md. b. COUNTY Kent c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Georgetown d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First John Middle Welch Last Welch					4. DATE OF DEATH Month May Day 27 Year 1961						
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 6, 1881		9. AGE (In years last birthday) 80 yrs. IF UNDER 1 YEAR: Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Boat Captain					10b. KIND OF BUSINESS OR INDUSTRY Boat. Commercial		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Aaron Welch					14. MOTHER'S MAIDEN NAME Mary Woodall						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)					16. SOCIAL SECURITY NO. 216-16-7329		17. INFORMANT Aaron W. Welch, Address Raleigh, North Carolina				
18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) Acute Coronary occlusion with Massive infarction 42011 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) My DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from May 26 1961 to May 27 1961 , that (I) (we) last saw the deceased alive on May 27 1961 , and that death occurred at 9:10 AM , from the causes and on the date stated above.											
22a. SIGNATURE Wallace Obenshain					22b. DATE 29 May 1961		22c. PHYSICIAN'S NAME (Type) Wallace Obenshain, M.D.				
22d. ADDRESS Cecilton, Md.											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF May 30, 1961		23c. NAME OF CEMETERY OR CREMATORY Georgetown Cemetery		23d. LOCATION (City, town or county) (State) Georgetown, Kent Co; Md.				
24. FUNERAL DIRECTOR'S SIGNATURE Edward Fellows, Millington, Md.					25a. REC'D BY REGISTRAR JUN 1 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Hines				

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